

(Re)imagining the ‘backstreet’: Anti-abortion campaigning against decriminalisation in the UK

Dr Pam Lowe

p.k.lowe@aston.ac.uk

School of Languages and Social Sciences, Aston University, Birmingham, B4 7ET

Orcid ID 0000-0001-5933-453X

Author Bio

Dr Pam Lowe is a senior lecturer in sociology and social policy. Her main research area is centred around women’s reproductive and sexual health and she has research includes issues around birth control, pregnancy and motherhood. She has recently completed projects on the deployment of neuroscience in parenting and child sexual exploitation. Her most recent book *Reproductive Health and Maternal Sacrifice: Women, Choice and Responsibility* was published by Palgrave in 2016.

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Abstract

The risk of death or serious injury from ‘backstreet abortions’ was an important narrative in the 20th century campaign to liberalise abortion in the UK. Since then, clinical developments have reduced the overall health risks of abortion, and international health organisations have been set up to provide cross-border, medically safe abortions to places where it is unlawful, offering advice and, where possible, supplying abortion pills. These changes mean that pro-choice campaigns in Europe have often moved away from the risks of ‘backstreet abortions’ as a central narrative when campaigning for abortion liberalisation. In contrast, in the UK, anti-abortion activists are increasingly using ideas about ‘backstreet abortions’ to resist further liberalisation. These claims can be seen to fit within a broader shift from morals to risk within moral regulation campaigns and build on anti-abortion messages framed as being ‘pro-women’, with anti-abortion activists claiming to be the ‘savers’ of women. Using a parliamentary debate as a case study, this paper will illustrate these trends, and show how the ‘backstreet’ metaphor within anti-abortion campaigns builds on three interconnected themes of: ‘abortion-as-harmful’; ‘abortion industry’ and ‘abortion culture’. The paper will argue that the anti-abortion movement’s adoption of risk-based narratives contains unresolved contradictions, due to the underlying moral basis of their position. These are exacerbated by the need, in this case, to defend legislation that they fundamentally disagree with. Moreover, their attempts to construct identifiable ‘harms’ and vulnerable ‘victims’, which are components of moral regulation campaigns, are unlikely to be convincing in the context of widespread public support for abortion.

Introduction

The risk of death or serious injury from ‘backstreet abortions’ was an important narrative in the campaign to liberalise abortion in the UK in the lead up to the passing of the 1967 Abortion Act. Whilst the exact numbers were always disputed, there was a general acknowledgement that illegal abortions were a source of morbidity and mortality. Since that time, clinical developments have reduced the health risks of abortion, including some which take place illegally. The abortion pill combined with the emergence of international health organisations who provide advice and distribute medication to regions like Northern Ireland¹ where abortion is restricted means that safe, unlawful abortion is increasingly available (Aiken et al., 2017). As the previous conflation of illegal and unsafe becomes increasingly difficult to draw on, those in favour of abortion liberalisation have often moved away from the ‘backstreet’ as a central narrative in their campaigns. In contrast, although previously the idea of the ‘backstreet abortion’ was not prominent to their claims, anti-abortion activists increasingly seem to be adopting the narrative of the ‘backstreet’ and are using it to resist further liberalisation, such as decriminalisation or the ability to take the abortion pill at home (for example see Society for the Protection of Unborn Children (SPUC), 2018). These claims can be seen to fit within a broader shift from morals to risk within moral regulation campaigns and

build on a framing of anti-abortion messages as being ‘pro-women’, and as anti-abortion activists as the ‘savers’ of women. This paper adds to the growing literature outlining the emphasis on risk within policy initiatives surrounding the family, and how this relates to wider trends towards governmentality (Lee, 2014). It also illustrates how assumptions about motherhood are embedded within debates about abortion and the broader responsabilisation of women continues to dominate how women are perceived within reproductive health (Lowe, 2016).

The framing of abortion has an important impact on the way that it is perceived (Kumar et al., 2009). The term ‘backstreet abortion’ is a signifier which is utilised in different ways. At a basic level it suggests abortions that are illegal and/or unsafe, often with a conflation of these two positions. It can also suggest ideas about abortion being dirty or shameful, or reflect images of ‘unscrupulous’ practitioners, who may or may not be qualified, taking advantage of ‘desperate’ women. The wire coat-hanger has become a widely recognised symbol of ‘backstreet abortions’, and is used in pictures or held up at demonstrations by pro-choice campaigners (Figure 1). The coat-hanger represents practices of inserting dangerous objects in order to end a pregnancy and thus signifies the potential catastrophic impact of restricting access to abortion. Although even before the 1967 Abortion Act, illegal abortions were not always unsafe, even if carried out by unqualified practitioners², in the UK, unsafe abortions were the most significant cause of avoidable maternal deaths by the mid-1960s (Brookes, 1988).



Figure 1: Wire coat hangers held up at a pro-choice counterdemonstration against an anti-abortion rally (Birmingham, May 2017)

In contrast to the focus on illegal/unsafe ‘backstreet abortions’ within pro-choice campaigns, anti-abortion activists have usually seen abortion in general as ‘harmful’ to women, regardless of the circumstances. During the debates surrounding the 1967 Act, whilst they sometimes disputed the number of women harmed by unsafe abortion, the more common frame of their argument was that liberalising abortion was not in women’s interests. Alongside stating that abortion was against the sanctity of life, claims were made about the impact on women including that it causes a ‘hardening of the personality’ and induces ‘guilt’ (Hindell and Simms, 1971:96). These claims are very similar to later ones which focus on women’s mental health (Lee, 2003) and illustrate how the ‘abortion-as-harmful’ narrative has been present in the UK since at least the 1960s.

This paper emerges from a broader ethnographic study on anti-abortion activism in the UK. It uses the Parliamentary debate over the Reproductive Health (Access to Terminations) Bill (2017)³ (RHAT) as a case study to illustrate some of the current narratives of the anti-abortion movement. RHAT was

introduced to Parliament as a ten minute rule bill. Ten minute rule bills are private members' bills and are often used as a way for backbench MPs to introduce an issue to Parliament. In speeches, no longer than ten minutes long, a proposer makes a case for legislation and an opposing speech can disagree. At this stage, the proposed law is not written in detail, but if there is a vote in favour, the bill can go on to be developed for its first reading. Hence the speeches made both in favour and in opposition set out the position of both sides and thus can be a useful way of determining what they think are the main strategic arguments to make⁴. In the case of RHAT, Diane Johnson (MP Kingston upon Hull North) was the proposer and Maria Caulfield (MP Lewes) made the opposition speech. At the time of the debate Johnson, was the chair of the All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health which advocates for abortion rights, Caulfield was a Vice Chair of the Pro-Life APPG which holds an anti-abortion stance. APPGs are often a way to work closely with organisations outside of Parliament. For example, Right to Life (a British anti-abortion organisation) has provided secretarial services to the Pro-Life APPG.

The paper situates the anti-abortion movement as a moral regulation campaign and illustrates its use of a risk-based discourse in challenging abortion. It will examine the extent to which anti-abortion campaigns are building on the image of 'backstreet abortions' as a way of challenging further liberalisation of abortion in the UK. It will argue that whilst the emphasis on risk within the anti-abortion campaign attempts to place a strategic distance from holding a moralising stance, they are unable to effectively distance themselves due to their underlying beliefs about women, motherhood and abortion. It will also show how the adoption of a risk-based framework, which sits uneasily with their core beliefs, poses difficulties for them, especially when having to defend legislation that they actually oppose.

Abortion law and reform initiatives

Under the 1861 Offences against the Person Act (OAPA), abortion is punishable by life imprisonment for women and anyone who assists her. The offence, and punishment, remains on the statute book in relation to England, Wales and Northern Ireland. In Scotland abortion was a crime under common law and did not carry the same punishment. Over the course of the early 20th century, access to medically supervised abortion became increasingly possible and the legality of this was tested in the Bourne case in 1938 which set a legal precedent. This case tested the law in relation to abortions carried out by doctors to save the life of women and established a precedent for women deemed to be at risk of becoming a 'physical and mental wreck' (Sheldon, 2016). Sheldon argues that this, and other cases:

Distinguish[ed] between 'respectable', qualified medical providers of abortion acting within the bounds of good medical practice and unscrupulous, unqualified backstreet abortionists, operating for profit (1997:80)

Whilst the Bourne case clarified that lawful abortion was possible, it was usually private doctors that performed abortions, hence the risk of injury and death was disproportionately felt by poor women who had little alternative but to turn to 'backstreet' providers.

The Abortion Law Reform Association's (ALRA) campaign for abortion liberalisation made use of existing data on the deaths and injuries caused by 'backstreet abortions' as well as conducting their own research into the issue. In 1965, a team visited shops such as chemists and herbalists in London and Birmingham and collected the products sold to them to 'bring on' a period or terminate a pregnancy (Hindell and Simms, 1971). Hindell and Simms (1971) state that ALRA were sold a variety of costly items which were unlikely to induce abortions but could be harmful to women and a

developing foetus. The 1967 Abortion Act was the culmination of a long campaign by ALRA and it provides legal exceptions to OAPA, significantly widening the conditions under which lawful abortion can take place. At that time, unlike the other countries, Northern Ireland had a devolved government and it was excluded from the legislation due to its hostility towards the liberalisation of issues surrounding sexuality (Whitaker and Horgan, 2017). The remit of the 1967 Act was to place abortion under medical control, by giving doctors the power to determine if an abortion meets the criteria of the Act as well as mandating that abortion procedures should take place within NHS or other approved premises (Sheldon, 1997, 2016). Concerns over 'backstreet abortions' were a significant issue during the Parliamentary debates prior to the passing of the 1967 Act (Sheldon, 1997). Sheldon (1997) argues that those in favour of abortion reform wanted to reduce the rates of mortality and morbidity, and many of them felt that doctors were also the best people to understand the circumstances of women. This institutionalised medical paternalistic position is clearly out of step within current understandings of patient autonomy (Sheldon 2016). Overall, the understanding that 'backstreet abortions' were dangerous to women was a crucial element in the introduction of the Abortion Act. At this point in time, some of the anti-abortion activists allowed for abortions to preserve women's life although others maintained an absolutist stance (Hindell and Simms, 1971). However in general, those opposed to abortion accepted that women were harmed due to 'backstreet abortions', but argued that all abortion was 'harmful', and thus did not necessarily distinguish between 'backstreet' and medically supervised abortions (Hindell and Simms, 1971).

Following the liberalisation of abortion in Britain and in other places, the abortion as harmful narrative continued to be a significant discourse for anti-abortion groups. In particular, during the 1990s claims about abortion causing mental health issues solidified through the construction of 'post-abortion syndrome' (PAS). As Lee (2003) documented 'PAS' was developed as a variation on post-traumatic stress disorder. Whilst the risk of 'PAS' is central to many anti-abortion campaigns, mainstream medical research has not found evidence in high quality studies to support claims of its existence (see for example Academy of Medical Royal Colleges, 2011). The emphasis on 'PAS' was part of a broader shift towards a 'women-centred strategy' (Cannold, 2002), in which many anti-abortion campaigners in different parts of the world shifted the emphasis of their campaigns away from a focus on the foetus and the religious/moral arguments that had failed to have a significant impact (Cannold, 2002; Lee, 2003; Oaks, 2000; Saurette and Gordon, 2015). As Lee's (2003) study showed, unlike in the United States, in Britain, the shift from moral concerns focused on the foetus, to medical concerns focusing on women's health, had very little traction and did not really shift the terms of the debate. In Northern Ireland, political debates have also included an increased emphasis on the protection of women, which has been used by politicians to resist law reform (Pierson and Bloomer, 2017).

A recent example of anti-abortion activism based on the notion of abortion 'harm' was around calls to legislate to increase regulation of pre-abortion counselling in Britain. As Hoggart (2015) showed, those that supported requiring women to seek counselling from non-abortion providers usually positioned women as at risk from abortion-related trauma rather than needing support in making their own decision. The anti-abortion position taken in parliamentary debates centralised concerns about women's health and vulnerability, suggesting that abortion service providers could not be trusted to provide care (Lee, 2013), although their attempts failed to gain enough Parliamentary support to proceed. The construction of abortion as inevitably 'harmful' is, however, more than just a tactical choice. Anti-abortion activists have specific understandings about women which arise from notion of separate spheres in which womanhood and motherhood are conflated (Lowe and Page, 2018a). Their understanding of women as '*mothers*' leads to a belief that women would never

‘naturally’ choose an abortion and an assumption of coercion either directly from partners, friends or family or more broadly through societal pressures (Lowe and Page, 2018a). From this perspective, women who have abortions are always ‘victims’, and the ‘harms’ of abortion encompass both medically supervised and ‘backstreet abortions’.

The continuing criminalisation of women seeking abortion, with the potential of long prison sentences is a legacy of the 19th century that few now would support regardless of their position on abortion. For example, although Northern Ireland is usually considered more conservative than the mainland, the Life and Times Survey revealed strong opposition to the prosecution of women who bought abortion pills unlawfully with 70% stating that abortion should be medically regulated rather than subject to criminal law (Gray, 2017). Even those opposed to abortion often reject punishing women as this would conflict their positioning of women as victims (Joffe, 2017). As Sheldon (2016) has shown, the provisions of the Abortion Act prevent normal development of services. For example, although midwives can now prescribe misoprostol in other circumstances, they are prevented from doing so in abortion care due to the stipulation of doctors approving treatment within the legalisation. It also produces a chilling and stigmatised environment for abortion service providers (Sheldon, 2016). The arguments for decriminalisation thus include treating abortion in the same way as other clinical procedures, and that stigma will be reduced through removing the threat of prosecution.

The willingness of those opposed to abortion to try to use the Act to prosecute doctors has been illustrated by Lee (2017). She outlines how following a newspaper report which claimed to have ‘discovered’ sex selection abortion, doctors who provided abortion were constructed as ‘villains’ and this notion was solidified through the statements and actions of the Secretary of Health. Sex selection abortions were constructed as a significant social problem despite the lack of evidence, and the ultimate rejection of a change to abortion law (Lee, 2017). As Lee (2017) has shown, the vilification of doctors within the sex selection debates is a sharp contrast to the structural position of medical paternalism written into the legal framework. In this case, rather than denying women abortions, doctors were seen as making it too ‘easy’ to obtain an abortion. Importantly, this was not seen as affirming women’s autonomy within medical decision-making, instead, the debates positioned this as acting to the detriment of women. The framing of this argument focused on the risks to women, positioning them as potential victims and aligned doctors with those who were positioned as coercing women (Lee, 2017). Identifiable victims who are at risk of harm are an important component of moral regulation campaigns.

Moral Regulation and Risk Narratives

Hunt (1999) argues that moral regulation movements always need to be understood within the context of the society in which they are based. He suggests that currently there are two general prevailing strategies, retraditionalisation and self-help, and these can be connected to broader neoliberal trends in which governance is operationalised through individual responsibility. Hunt (1999) argues that moral regulation movements often now make scientific claims, for example through shifting warnings of harm from ‘vice’ and ‘sin’ to concerns about health. The emphasis is often on encouraging individuals to reject ‘unhealthy behaviour’, as a way to reduce the risk of harm. Alongside this, he suggests that they often advocate for, or support, authorities in enacting disciplinary techniques, merging both disciplinary governance of others with advocating self-reform. Broadly speaking, this twin track approach can be seen within the anti-abortion movement in the UK whose focus encompasses calls for legislative reform to reduce abortion access as well as appeals

directly to women, for example through activities directly outside abortion clinics (Lowe and Hayes, 2018b). In recent years, anti-abortion bills in Parliament have unsuccessfully sought to restrict access by focusing on specific issues such as foetal sex, disability or later abortions. As McGuinness (2015) argues, the anti-abortion movement has often strategically switched to a piecemeal approach which seeks to restrict specific 'difficult' abortions alongside other tactics which seek to stigmatise and marginalise abortion and abortion service providers. By focusing on 'difficult' abortions, anti-abortion activists aim to gather support from those who would not countenance an outright ban, and construct new categories of victims at risk of specific harms.

Like arguments premised on health issues, calls for abortion to be banned on the basis of sex selection and/or disability, reject overtly moralising claims about the nature of abortion itself and instead focus on the risk to 'vulnerable populations'. Gandsman (2016) found similar trends in his study of campaigns against euthanasia⁵. He argues that despite the activists' moral beliefs being the motivation for their involvement, publically they deployed narratives of risk and a corresponding need to protect the vulnerable from abuse. Gandsman (2016) suggests that the emphasis on potential harm allows religious people to avoid being seen to impose their religious framework on others as this is a more 'inclusive' framework. The aim is for their construction of 'risk' and 'victims' to be accepted by others who would not necessarily accept their moral argument straightforwardly. However, as Gandsman (2016) has shown, in their desire to conceptualise their moral beliefs about assisted dying as a form of elder abuse, they have ended up rely on false premises and disingenuous arguments based on misreading of official data.

Similar trends can be seen within the anti-abortion movement. Many anti-abortion groups have adopted 'science' narratives which seek to explain the 'harms' of abortion (Lowe and Page 2018a; Lee, 2003) and this could be seen as a shift towards governmentality. As outlined above, the 'harms' of abortion are often presented as a health-based risk. Risk based narratives often have a focus on future 'harm', and advocate a change in behaviour now to prevent adverse consequences later (Hier, 2016). More generally, as Lee (2014) has shown, risk consciousness is currently an important element of family policy in the UK, and has become an important frame for moral concerns about children and families. Risk consciousness reconceptualises risk as danger rather than a balance of possibilities, and both individualises, by designating individuals as 'at risk', and generalises harms to a wider population, thus justifying surveillance of individuals and families (Lee 2014). Anti-abortion claims about the impact of abortion are framed in this way. At an individual level, women's future wellbeing is designated as at risk due to 'PAS' if they have abortions, and the negative effects can manifest themselves at any future time (Lee, 2003). More broadly, they suggest that 'abortion culture' has 'damaged' society. Whilst individuals vary as to the exact reasons, this can include ideas about encouraging a denigration of responsibility, population loss, encouraging promiscuity, a threat to 'natural' gender roles and defying God's will (Lowe and Page, 2018a; Munson, 2002).

The individualisation of risk produces the responsabilisation of women in the area of reproductive health including abortion (Author, 2016). Those who hold an anti-abortion position expect women to sacrifice all other aspects of their lives and continue with pregnancies regardless of their cost to themselves (Lowe, 2016). The emphasis on retraditionalisation can be seen within their appeals to individual pregnant women to reject abortion, particularly amongst the anti-abortion groups that target women directly outside clinics which often focus on women as '*mothers*' (Lowe and Page, 2018a). Their encouragement to individual women to reject abortion clearly also includes an element of self-help, through recognising themselves as 'mothers'. It is important to understand that whilst this does position women as potentially self-governing citizens, it is only in the context of choosing to proceed with the pregnancy. Those who elect to have abortions are always 'victims' as

they have acted outside the traditional roles for women that the anti-abortion activists believe are 'natural' (Lowe and Page, 2018a). Hence reducing the risks to women would mean, for anti-abortion activists, decreasing or eliminating abortions either through legal changes or by 'saving' individual women through activities outside clinics or other crisis pregnancy interventions.

Risk-based arguments are also used in the pro-choice campaigns for the decriminalisation of abortion. It argues that the current legal framework is harmful, an impediment to clinical care, and contributes to the stigmatisation of abortion. The threat of life imprisonment is seen as an anachronism, and one that sets up a chilling environment for healthcare practitioners. It also may unwittingly criminalise women who may not understand that they are committing an offence if they buy abortion pills online. The structures of the Abortion Act, with its focus on doctors and registered places was written for a time of surgical abortions rather than abortion medication and has prevented the development of services, such as those which are nurse-practitioner led. The law is seen as a part of the historic legacy of discrimination against women, contributing to the ongoing stigmatisation of abortion, rather than situating it as healthcare. Decriminalisation could also allow abortion access in Northern Ireland, although whether or not Northern Ireland should be included in Westminster legislation is a matter of debate⁶. As Diane Johnson make clear in Parliament when she introduced her decriminalisation bill, abortion was just being moved into normal healthcare frameworks. She emphasised that decriminalisation will not prevent continuing regulation to ensure high standards. Johnson explicitly rejected that decriminalisation would return abortion to the 'free-for-all' of 'unlicensed practitioners' (HC 13/03/2017 Vol 623 C27). This explicitly rejects the notion that decriminalisation would pose a risk of returning to the 'backstreet'. Moreover, the emphasis on good clinical practice reiterates the positioning of abortion as a medical rather than a moral issue. The anti-abortion opposition does not challenge this broad framing, but instead makes links from their understanding of medical 'harms' to the broader problematisation of abortion, drawing on the image of 'backstreet' abortions when making their claims

'Dangerous' to Women

'Far from being progressive, the Bill would be a charter for unsafe abortion practices, not dissimilar to the back-street abortions that the Abortion Act 1967 was supposedly meant to end (...) It would not protect women'. Maria Caulfield MP – opposing RHAT (HC 13/03/2017 Vol 623 C28-30)

Since the passing of the 1967 Abortion Act, there have been numerous attempts by MPs opposed to abortion to try to restrict it. In contrast, the current campaign for decriminalisation of abortion has placed anti-abortion activists in a position whereby they are forced to defend legislation that they are fundamentally opposed to, in order to prevent further liberalisation. They draw heavily from their understanding of all abortions as unsafe, including those that are medically supervised and in line with the current legislation. Thus their arguments seem to undermine their defence of the current legal framework. In the speech, Caulfield highlights many of the 'harms' of abortion that are central to current anti-abortion campaigning which often fall into three main areas: abortion as dangerous to women's health and wellbeing, their perception of the 'abortion industry' and the 'abortion culture' more generally.

As set out above, anti-abortion discourse has often positioned abortion as 'harmful' to women, and thus it is no surprise that the health 'risks' to women are highlighted in the opposition to decriminalisation. Caulfield states abortion is 'a major and often risky procedure' (HC 13/03/2017 Vol 623 C29). The medical evidence that abortion is often safer than continuing a pregnancy (Sheldon, 1997) is not a position that anti-abortion campaigners are likely to accept. References to

ongoing health issues are, for example, frequently used in leaflets handed to women outside abortion clinics in an effort to deter them from entering⁷. Caulfield goes on to argue that the criminalisation of abortion is necessary to prevent internet purchase of abortion pills which are 'potentially dangerous products' (HC 13/03/2017 Vol 623 C29). Notably here, whilst there is clearly a link to the 'backstreet' provision in making reference to an internet trade in abortion pills, Caulfield does not make a clear distinction between abortion being risky generally and unlawful purchases being potentially unsafe. All abortion pills are positioned as the 'dangerous product', rather than an irregular trade which could potentially include a fake or contaminated supply. The notion that abortion pills are unsafe is a claim that has also been made in opposition to the announcement by the Scottish Government that women would be able to take the medication at home (for example see Life, 2017). The inherent 'dangers' of abortion is a core anti-abortion belief (figure 3), based on their understanding of women's nature and a 'risk' to mental health (Lee, 2003; Lowe and Page, 2018a). However, it is unlikely to be a convincing argument for the majority of the public who support abortion (Park et al., 2013) and, given the frequency of abortion, are likely to know people who have not been traumatised by their decision.



Figure 2: 'Abortion Hurts Women' sign outside a hospital claiming abortion is 'harmful' (Edinburgh, March 2017)

A recurring argument in the anti-abortion position is the notion of women as victims of abortion coercion (Figure 3). The belief that women are either directly or indirectly coerced into abortion stems from anti-abortion beliefs about motherhood being central to women's nature which means that women would never really 'choose' abortion. This is a central element in Caulfield's argument. She suggests that the law provides a safeguard for 'terrified' teenagers and from 'men who pressurise women' (HC 13/03/2017 Vol 623 C30). The requirement that two doctors certify the abortion is presented as a 'safeguard' for women - placing doctors in the position of a potential protector from abuse. Caulfield suggests that this is the way that women make 'informed choices' (HC 13/03/2017 Vol 623 C30). Within anti-abortion discourse, an 'informed choice' is usually one in which women choose not to have an abortion, in line with their beliefs that women are always coerced (Lowe and Page, 2018a). The belief that it is the role of doctors to support women into potentially not having abortions was part of the medical paternalism built into the current law in which doctors rather than women formally make the decision. However, rather than seeing this as an outdated discriminatory concept, it is promoted by the anti-abortion argument against decriminalisation as a necessary safeguard to protect women.

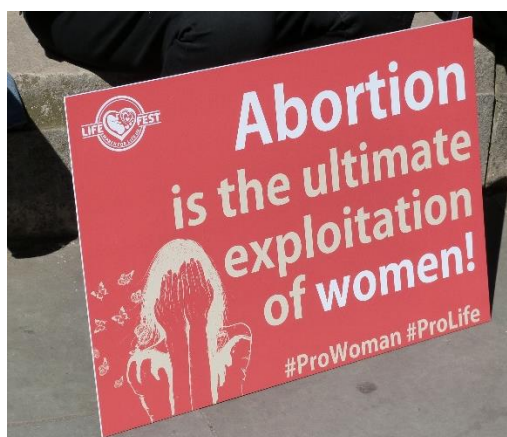


Figure 3: Sign at an anti-abortion rally (London, May 2018) implying potential coercion

Yet the anti-abortion positioning of doctors as the potential saviours of women is a direct contradiction to Caulfield's criticism of abortion service providers. She suggests that the 'abortion industry' is 'knee-deep (...) in unethical, unsafe and unprofessional practice' (HC 13/03/2017 Vol 623 C30). The use of the word 'industry' and emphasis on 'private abortion providers' (HC 13/03/2017 Vol 623 C30) is clearly meant to signal a profit-driven practice in which care is compromised and is part of the vilification and stigmatisation of healthcare professionals involved in abortion (Lee, 2003, 2017; McGuinness, 2015). As Lee (2003) showed, the notion of an 'abortion industry' was developed in the US, but has very little relevance in Britain where almost all abortions are state funded, even when carried out in private or charitable abortion clinics. Caulfield highlights several areas to promote the idea of 'unprofessional practice' including doctors pre-signing abortion approval forms and a lack of staff training at one provider. As Sheldon (2016) has pointed out, the pre-signing of forms was only found to have taken place in a small number of NHS Trusts, which most people would not consider as part of an 'industry'. In addition, there was no evidence of poor care found to be associated with this practice. Whilst pre-signing forms suggests a lack of medical oversight and to potentially be a barrier to forming a 'good faith' judgement required by the Act, there is actually no requirement in the legislation or regulations that two doctors see the women in person (Sheldon, 2016). For early medical abortion, other health professionals such as nurses can perform all necessary tasks providing they are formally supervised by doctors. More generally, healthcare providers do sometimes fail to provide good clinical care, but, as the inspection of many NHS facilities have shown this is neither specific to abortion nor the private sector (for an overview see Glasper, 2017).

The positioning of abortion service providers as motivated by greed, rather than women's health, has often been mentioned within anti-abortion campaigns against the imposition of no-protest zones around abortion clinics. For example, on their website SPUC claims abortion clinics 'stand [...] to lose out financially every time a woman is helped to choose life for her baby' (SPUC, n.d.). The claims that abortion service providers are motivated by profit is not a new anti-abortion strategy. For example, in the 1970s, newspaper journalists claimed that doctors were 'performing' abortions on women that were not actually pregnant (Litchfield and Kentish, 1974), claims that were not substantiated (Francome, 1984). In addition, attention was also drawn to abortion tourism with accounts of 'foreign girls' flying in for abortions often featuring in the media (Hindell and Simms, 1971). Whilst there were private abortion providers, particularly in London, who provided services to

women who could not access abortion elsewhere, as the Lane Committee (1974)⁸ found, although there was some profiteering, a lack of abortion access was at the heart of the issue. The current construction of a profit-driven, unsafe 'abortion industry' seems to be built on earlier similar discourses which sought to overturn or limit the Abortion Act. It builds on the 'unscrupulous operators' elements of the 'backstreet' narrative despite the abortions being lawful and carried out by health professionals. However, within the debates over decriminalisation, this strand of the anti-abortion argument is in stark contradiction to the apparent support of the role of doctors as essential, potential protectors of women. There is an unresolved conflict between positioning doctors as trusted gatekeepers, which is necessary to defend the 1967 Act, and 'unprofessional profiteers' positioned as 'backstreet' which is the more common understanding of abortion service providers within the anti-abortion movement.

The final area underpinning the anti-abortion arguments in the speech is what anti-abortion activists refer to as 'abortion culture' – that is the broader changes in society which they believe encourages abortion decisions and the negative impacts that they believe abortion causes. Whilst this is not a significant argument within the speech, there are elements to be seen. Caulfield makes reference more than one to the dignity and rights of women and claims that current 'abortion culture' treats women as a 'victim of her own body' (HC 13/03/2017 Vol 623 C31). These points signal the ways in which they position motherhood as central to women's lives, and access to abortion is seen as a risk, undermining of women's position as 'mothers'. This arises from their beliefs in abortion coercion in which cultural pressures on women which causes them to deny their 'natural' inclinations towards motherhood (Lowe and Page, 2018a). In addition, when juxtaposed to the vilification of doctors, this 'women as victims' position implicitly implicates the providers of abortions as providing or supporting the coercion (Lee, 2017). Importantly though, the emphasis on positioning women as 'at risk' and needing protection is difficult to sustain within the current abortion law in which they are potentially criminalised. To overcome this contradiction, Caulfield claimed that the law is not an issue because prosecutions rarely occur, and only do so in extreme cases. However, it is difficult to argue convincingly for a law in which you seek to safeguard 'victims' by threatening them with prosecution.

Caulfield also suggests that the provision of abortion treats 'children as commodities' (HC 13/03/2017 Vol 623 C31). This argument could be positioned as being part of a wider concern about the commercialisation of childhood in which children are often situated as the 'innocent' victims of manipulation and exploitation (Cook, 2004). This understanding of the 'sacred' nature of children and childhood is compatible with more generalised concerns about changes to the position of women in society. Whilst in the speech, the arguments about problematic 'abortion culture' were not directed at the specifics of the debate as to if abortion should continue to be criminalised, they are nevertheless symptomatic of their wider opposition to abortion. These claims do not make reference to the 'backstreet' metaphor, tangentially however they still support ideas about 'inappropriate commercialisation, by 'unscrupulous practitioners'.

Conclusion

The general shift by moral regulation movements towards strategies highlighting risk rather than moral concerns (Hunt, 1999) was undertaken during the 1980s by the anti-abortion movements both in the UK and elsewhere (Lee, 2003). The shift towards a framing around risk and abuse enables the downplaying of religious motives (Gandsman, 2016) and is in line with the risk consciousness focus of family policy debates more generally (Lee, 2014). Yet as Lee (2003) argues, whilst focusing on risk rather than overt moral arguments, suit the existing legal framework in Britain as abortion is situated as a medical concern, it failed to make any headway either in political or legal terms. Whilst

there have been many attempts to restrict abortion law since 1967, it has remained largely unchanged. The emphasis, for example, on 'PAS' has largely been an unsuccessful strategy, both in terms of legislative failure at Westminster and wider public attitudes to abortion. Whilst the idea that vulnerable women need protection from abortion has contributed to the ongoing lack of abortion in Northern Ireland, other arguments have also played a significant role there (Pierson and Bloomer, 2017).

The framing of abortion is an important part of its conceptualisation. It contributes to, and is informed, by political debates (Lee, 2017; Pierson and Bloomer, 2017) as well as furthering its ongoing stigmatisation (Kumar et al., 2009). Sheldon (1997) argues that whilst the medical framing of abortion within the Abortion Act overlooks women's autonomy, it has also supported the rejection of claims on behalf of both male partners and the foetus. The medical framing was established on the back of concerns to women's health from 'backstreet abortions' in which the risk from a *lack of access* to abortion was central to the passing of the Abortion Act. As 'backstreet abortions' were central to the medico-legal framing, it is perhaps unsurprising that they would feature as part of the defence of the existing legal framework. The difficulty for the anti-abortion movement is that clinical developments have meant abortion is significantly safer than it was, even when, such as in Northern Ireland, many women are accessing abortion unlawfully (Aiken et al., 2017). The current UK legal framework of abortion potentially criminalises women. From a position in which women are positioned as 'victims' of abortion, the current law is difficult to defend. However, a risk-based framing needs a potential victim, and to revert to a foetal-centric campaign, would draw attention to the moral rather than medical motives of those opposed to abortion. Moreover whilst in the moral anti-abortion framing, women *as mothers* are understood to normally want to accept responsibility for continuing the pregnancy, within wider society, the responsabilisation of women includes an emphasis on preventing motherhood if their circumstances places them as likely to become 'bad' mothers (Lowe, 2016). In this scenario, the risk-based framing leans towards abortion in order to prevent future harms.

The parliamentary debate over RHAT provides a useful case study of anti-abortion discourses in the UK. It highlights the extent to which the adoption of a risk-based strategy to resist abortion liberalisation is unable to fully distance itself from the underlying moral concerns of those opposed to abortion. The three interconnected themes within the anti-abortion opposition, 'abortion-as-harmful', 'abortion industry' and 'abortion culture' are rooted in objections which arise from the moral understandings about women, motherhood and abortion, and how these lead to assumptions about abortion coercion. Whilst the 'backstreet' narrative includes notions of 'unscrupulous providers', as abortion is clearly situated as a state-funded healthcare procedure which has widespread public support, this is unlikely to be convincing. Moreover the vilification of doctors within anti-abortion understandings of an 'abortion industry' appears as a direct contradiction to a need to defend medical gatekeeping which is at the heart of the 1967 Abortion Act. Risk-based narratives within moral regulation campaigns require the construction of identifiable harms and vulnerable victims. The current anti-abortion narratives have attempted to make this case in relation to women, using the image of the 'backstreet' as a way to defend the 1967 Act. However, the moral beliefs at the heart of anti-abortion movement undermines their current framing, and poses difficulties in trying to convey risk-based arguments, especially as they are trying to defend legislation that they actually oppose.

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¹ The 1967 Abortion Act did not apply to Northern Ireland and women seeking abortion either have to travel to the UK mainland or buy abortion pills unlawfully.

² Woodside's (1963) research with UK women imprisoned for carrying out abortions reports that many reported a history of success. In the US, the Jane Collective also carried out safe unlawful abortions (Kaplan 1995)

³ All Hansard references in this paper are from the debate in the House of Commons (HC 13/03/2017 Vol 623 C26-33)

⁴The anti-abortion movement consists of a number of different organisations who do not necessarily agree on a single strategy of campaigning, nevertheless their position on the potential decriminalisation of abortion are very similar.

⁵ Many of those opposed to abortion are also against euthanasia, although the two groups do not overlap completely. Thus it is not surprising that there are similarities in movement strategies.

⁶ **The lack of abortion in Northern Ireland has been found to breach human rights, and as the UK Parliament retains responsibility for human rights, increasingly there are calls for Westminster to legislate rather than the Northern Ireland Assembly. For example, see the Parliamentary debate on Offences Against the Person Act 1861 (HC 05/18/18 Vol 642 C205-257)**

⁷ For example, leaflets given out in Ealing, Birmingham and Manchester by different anti-abortion groups all make claims that abortion leads to depression, eating disorders and infertility. Breast cancer and alcohol abuse were mentioned on two leaflets.

⁸ The Lane Committee was established in 1974 to investigate the workings of the 1967 Abortion Act.